City and County of San Francisco

Department of Public Health
Environmental Health Management
1390 Market Street, Suite 210
San Francisco, CA 94102

Health Permit Application Zoning Referral

FOR HEALTH DEPARTMENT USE ONLY	
Date Application Filed:	HC: 1 2 3 4 5 6 CO
Date to Zoning:	Inspector:
Date from Zoning:	FPS FPM OTHER

TO BE COMPLETED BY APPLICANT
Applicant must complete both pages of this referral as indicated. Accurate information is required,
***False or misleading information may result in denial of the application*.**

1. NAME OF BUSINESS: _____

2. BUSINESS STREET ADDRESS: _____
What floor(s) will the business occupy? Check appropriate floor(s) below.

Basement Level ☐ **Street Level** ☐ **1st Floor** ☐ **2nd Floor** ☐ **3rd Floor** ☐ **Other Floor(s)**_____

3. IS THE BUSINESS A RETAIL CHAIN? Does the establishment have eleven or more locations throughout the U.S. per Planning Code Section 703.3 & 703.4?

YES ☐ **NO** ☐

Existing Use of This Space:
Special Note: If any other room or building is to be used in connection with this application: OR, if any part of the proposed operation is ***not*** *located within or connected to address above****, please attach an explanation sheet****.*

Applicant's Name:
Mailing Address:
City: **Zip Code:**
Applicant's Daytime phone: ( )
Floor Plans and Explanation Sheet attached? ☐ **Yes** ☐ **No**

FOR DEPARTMENT OF CITY PLANNING USE ONLY	
ZONING:	**BLK / LOT:** /
Limitations or Conditions (if any):	
APPROVED: **DATE:**	
(Planner's Signature)	
DISPPROVED: **DATE:**	
(Planner's Signature)	

APPLICANT: THIS IS PAGE 1 OF 2A or 2B –COMPLETE PAGE 2A ONLY IF THE BUSINESS IS A FOOD / BEVERAGE OR OTHER ESTABLISHMENT. COMPLETE PAGE 2B ONLY IF THE BUSINESS IS A MASSAGE, ACUPRESSURE, OR REFLEXOLOGY ESTABLISHMENT AND/OR SHOULD THE BUSINESS OFFER MASSAGE, ACUPRESSURE, OR REFLEXOLOGY AS AN ACCESSORY COMPONENT TO A BUSINESS.

WHITE: Establishment File Copy · YELLOW: Zoning File Copy · PINK: Interim copy